



New Patient Paperwork Packet

- Please complete ALL forms and return to the clinic once completed. The clinic will call you to schedule your first appointment. If you fail to complete all the forms, this will delay in scheduling your appointment.
- Please bring your Driver's License/photo ID AND your insurance card to your appointment.
- Please arrive 15 minutes early to your scheduled appointment time.
- If you arrive LATER than 10 minutes from your set appointment time, you may be deemed as a "NO SHOW". You will be expected to reschedule your appointment.
- Please bring a list of current medications or medication bottles to your appointment.
- You may want to bring a sweater or jacket with you as the office is usually cold.
- We ask that you wear a mask if you are feverish, sick, or not feeling well.
- ALL COPAYS MUST BE PAID AT TIME OF CHECK IN.
- We do NOT accept new pain management cases.

New Patient Paperwork Packet

PATIENT INFORMATION

LAST NAME	FIRST NAME		MIDDLE INITIAL	
DATE OF BIRTH	SEX <input type="checkbox"/> M <input type="checkbox"/> F	SSN		
MAILING ADDRESS	APT. #	CITY	STATE	ZIP
EMAIL	PRIMARY CARE PHYSICIAN			
LANGUAGE PREFERRED	RACE	ETHNICITY		
CELL PHONE NUMBER	EMERGENCY CONTACT NAME		EMERGENCY CONTACT RELATIONSHIP	
EMERGENCY CONTACT PHONE NUMBER	EMERGENCY CONTACT ADDRESS		GUARANTOR NAME	
GUARANTOR RELATIONSHIP	GUARANTOR PHONE NUMBER		GUARANTOR ADDRESS	

PREFERRED METHOD OF CONTACT? PHONE EMAIL MAIL

MAY WE LEAVE A MESSAGE ON YOUR ANSWERING MACHINE? YES NO

MAY WE COMMUNICATE WITH YOU THROUGH THE PATIENT PORTAL? YES NO

REASON FOR VISIT _____
 (List Symptoms)

ARE YOU OR IS THERE A POSSIBILITY YOU COULD BE PREGNANT? YES NO

HOW DID YOU HEAR ABOUT US?

Employer Google Mailer Personal Referral Road/Building sign Social Media Website Existing Patient

PRIMARY INSURANCE POLICY HOLDER

POLICY HOLDER'S NAME	SSN	DOB
INSURANCE NAME	INSURANCE I.D. #	
Group #	ADDRESS IF DIFFERENT THAN PATIENT'S	RELATIONSHIP TO POLICY HOLDER

SECONDARY INSURANCE POLICY HOLDER (if applicable)

POLICY HOLDER'S NAME	SSN	DOB
INSURANCE NAME	INSURANCE I.D. #	
Group #	ADDRESS IF DIFFERENT THAN PATIENT'S	RELATIONSHIP TO POLICY HOLDER

Signature of Patient/Guardian _____ Date _____

Name: _____ DOB: _____

Patient Medical History: Select all that apply to you

<input type="checkbox"/> ADHD	<input type="checkbox"/> Diverticulitis	<input type="checkbox"/> Liver Disease
<input type="checkbox"/> Acne	<input type="checkbox"/> Eating Disorder	<input type="checkbox"/> Lupus (SLE)
<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> Eczema	<input type="checkbox"/> Lymphedema
<input type="checkbox"/> Anemia	<input type="checkbox"/> Emphysema/Chronic bronchitis	<input type="checkbox"/> Mental Health
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Mitral Valve Prolapse
<input type="checkbox"/> Asthma	<input type="checkbox"/> GERD	<input type="checkbox"/> Multiple Sclerosis
<input type="checkbox"/> Atrial Fibrillation	<input type="checkbox"/> Gout	<input type="checkbox"/> Neurologic Problem
<input type="checkbox"/> Auto Immune Disorder	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Osteopenia/Osteoporosis
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Herpes Simplex Virus Type 1 or Type 2	<input type="checkbox"/> Prostate (BPH)
<input type="checkbox"/> Back pain	<input type="checkbox"/> Headache/Migraine	<input type="checkbox"/> Psoriasis
<input type="checkbox"/> Benign positional vertigo	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> SARS-COV-2 Date:
<input type="checkbox"/> Blood Clot	<input type="checkbox"/> Hepatitis A, B or C	<input type="checkbox"/> Seasonal Allergies
<input type="checkbox"/> Blood disorder	<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Seizures
<input type="checkbox"/> Cancer- Type:	<input type="checkbox"/> Hormonal Therapy	<input type="checkbox"/> Shingles (Herpes Zoster)
<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Human Papillomavirus (HPV)	<input type="checkbox"/> Sleep apnea
<input type="checkbox"/> Chron's Disease	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Stroke
<input type="checkbox"/> Congestive Heart Failure	<input type="checkbox"/> Incontinence	<input type="checkbox"/> Thyroid disorder
<input type="checkbox"/> Chronic Obstructive Pulmonary Disease (COPD)	<input type="checkbox"/> Influenza Year:	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Depression	<input type="checkbox"/> Insomnia	<input type="checkbox"/> Ulcerative Colitis
<input type="checkbox"/> Diabetes: Type 1 or Type 2	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Vertigo

Name: _____ **DOB:** _____

Immunization History:

<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk	Covid-19 Vaccine- Type: Pfizer, Moderna, J&J, Astra, Zeneca, Unknown Date(s): 1 st _____ 2 nd _____
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk	Tetanus Vaccine- Type: Tdap, Td, DTaP, Unknown Date: _____
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk	Shingles Vaccine- Type: Shingrix, Zostavax, Unknown Date(s): 1 st _____ 2 nd _____
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk	Influenza Vaccine- Type: Quadrivalent, High Dose, LAIV, Nasal, Unknown Date: _____

Surgical History: Select the following that apply to you

<input type="checkbox"/> Appendectomy	<input type="checkbox"/> Coronary Artery Bypass	<input type="checkbox"/> Hip: L / R	<input type="checkbox"/> Shoulder: L / R
<input type="checkbox"/> Breast Biopsy	<input type="checkbox"/> C-Section	<input type="checkbox"/> Hysterectomy	<input type="checkbox"/> Spine:
<input type="checkbox"/> Carpal Tunnel: L / R	<input type="checkbox"/> Foot: L / R	<input type="checkbox"/> Knee: L / R	<input type="checkbox"/> Thyroidectomy
<input type="checkbox"/> Cataract: L / R	<input type="checkbox"/> Gastric Bypass	<input type="checkbox"/> Mastectomy	<input type="checkbox"/> Tonsillectomy/ Adenoidectomy
<input type="checkbox"/> Cholecystectomy	<input type="checkbox"/> Hand: L / R	<input type="checkbox"/> Neuro:	<input type="checkbox"/> Tubal Ligation
Colon/Rectal:	Hernia:	<input type="checkbox"/> Prostatectomy	<input type="checkbox"/> Tympanostomy (PE Tube)
Other Surgeries:			

Family History: Select the following that apply to you

Family	Alive/Deceased	Medical Problems
Mother		<input type="checkbox"/> Hypertension, <input type="checkbox"/> Diabetes, <input type="checkbox"/> Stroke, <input type="checkbox"/> Heart Disease, <input type="checkbox"/> Cancer <input type="checkbox"/> High Cholesterol, <input type="checkbox"/> Thyroid Disease, <input type="checkbox"/> Myocardial Infraction, <input type="checkbox"/> Anxiety, <input type="checkbox"/> Depression, <input type="checkbox"/> Other:
Father		<input type="checkbox"/> Hypertension, <input type="checkbox"/> Diabetes, <input type="checkbox"/> Stroke, <input type="checkbox"/> Heart Disease, <input type="checkbox"/> Cancer <input type="checkbox"/> High Cholesterol, <input type="checkbox"/> Thyroid Disease, <input type="checkbox"/> Myocardial Infraction, <input type="checkbox"/> Anxiety, <input type="checkbox"/> Depression, <input type="checkbox"/> Other:
Sibling(s)		<input type="checkbox"/> Hypertension, <input type="checkbox"/> Diabetes, <input type="checkbox"/> Stroke, <input type="checkbox"/> Heart Disease, <input type="checkbox"/> Cancer <input type="checkbox"/> High Cholesterol, <input type="checkbox"/> Thyroid Disease, <input type="checkbox"/> Myocardial Infraction, <input type="checkbox"/> Anxiety, <input type="checkbox"/> Depression, <input type="checkbox"/> Other:
Other: _____		<input type="checkbox"/> Hypertension, <input type="checkbox"/> Diabetes, <input type="checkbox"/> Stroke, <input type="checkbox"/> Heart Disease, <input type="checkbox"/> Cancer <input type="checkbox"/> High Cholesterol, <input type="checkbox"/> Thyroid Disease, <input type="checkbox"/> Myocardial Infraction, <input type="checkbox"/> Anxiety, <input type="checkbox"/> Depression, <input type="checkbox"/> Other:
<input type="checkbox"/> Family History is unknown		

Social History: Select the following that apply to you

<input type="checkbox"/> No Alcohol Usage. <input type="checkbox"/> Alcohol Usage: Frequency: _____ per day / week	<input type="checkbox"/> No Tobacco Usage. <input type="checkbox"/> Tobacco Usage: _____ per day Type: <input type="checkbox"/> Vaping <input type="checkbox"/> Cigarettes <input type="checkbox"/> Cigars <input type="checkbox"/> Non-Smoking
--	---

Name: _____ DOB: _____

Medication History:

No Medication Usage

Medication (if you have more than the spaces, please bring a med list)	Dose	Frequency
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Pharmacy:

Cross Streets:

City:

Allergies:

Name:	Reaction:

Health Screening:

Please list the year of last health screening below:	Year Completed:
Colonoscopy	
Mammogram	
Pap Smear	
DEXA Scan	
PSA/Prostate	



Patient Health Questionnaire and General Anxiety Disorder:

(PHQ-9 and GAD-7)

Date: _____ Patient Name: _____ Date of Birth: _____

**Over the last 2 weeks, how often have you been bothered by any of the following problems?
Please circle your answers.**

PHQ-9	Not at all	Several Days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things.	0	1	2	3
2. Feeling down, depressed, or hopeless.	0	1	2	3
3. Trouble falling, staying asleep, or sleeping too much.	0	1	2	3
4. Feeling tired or having little energy.	0	1	2	3
5. Poor appetite or overeating.	0	1	2	3
6. Feeling bad about yourself or that you are a failure or have let yourself or your family down.	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3
8. Moving or speaking so slowly that other people could notice or the opposite, being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all Somewhat difficult Very difficult Extremely difficult

**Over the last 2 weeks, how often have you been bothered by any of the following problems?
Please circle your answers.**

GAD - 7	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge.	0	1	2	3
2. Not being able to stop or control worrying.	0	1	2	3
3. Worrying too much about different things.	0	1	2	3
4. Trouble Relaxing	0	1	2	3
5. Being so restless that it's hard to sit still.	0	1	2	3
6. Becoming easily annoyed or irritable.	0	1	2	3
7. Feeling afraid as if something awful might happen.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all Somewhat difficult Very difficult Extremely difficult



Epworth Sleepiness Scale

Today's Date: _____

Patient Name: _____ Birth Date: _____

Patient Sex: Male Female

How likely are you to doze off or fall asleep in the situations described below, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to decide how they would've affected you.

Use the following scale to choose the most appropriate number for each situation:

0 = would never doze

1 = Slight chance of dozing

2 = Moderate chance of dozing

3 = High chance of dozing

Situation:

Chance of Dozing:

Sitting and reading..... _____

Watching TV..... _____

Sitting, inactive in a public place (e.g. a theater or a meeting)..... _____

As a passenger in a car for an hour without a break..... _____

Lying down to rest in the afternoon when circumstances permit..... _____

Sitting and talking to someone..... _____

Sitting quietly after a lunch without alcohol..... _____

In a car, while stopped for a few minutes in traffic..... _____

Total..... _____

Currently on CPAP therapy: Yes No

0 – 5 Lower than Normal Daytime Sleepiness

6 – 10 Higher Normal Daytime Sleepiness

11 – 12 Mild Excessive Daytime Sleepiness

13 – 15 Moderate Excessive Daytime Sleepiness

16 – 24 Severe Excessive Daytime Sleepiness

Anything above a 10 would be recommended for a sleep consultation

Please note that this is a GUIDE ONLY. Ultimately, the decision to refer a patient for a sleep consultation may be the result of a variety of factors and is at the sole discretion of the provider.



HIPAA Notice of Privacy Practices:

Patient Name: _____ Date of Birth: _____

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AS WELL AS HOW TO GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, healthcare operations, and for purposes required by law. This notice also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you. This information relates to your past, present, or future physical and mental health condition and related healthcare services.

Uses and Disclosure or Protected Health Information (PHI)

Your protected health information may be used and disclosed by your physician, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing healthcare services to you, to pay your healthcare bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third-party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you; OR your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has necessary information to diagnose and/or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your healthcare services. For example, obtaining approval for a medical procedure may require that your relevant protected health information be disclosed to the health plan to establish medical necessity.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to conduct normal operations of the physician's practice. These activities include, but are not limited to:

- Quality control
- Licensing
- Employee reviews
- Training of medical students

For example, we may disclose your protected health information to medical students that see patients in our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may use or disclose your protected health information, as necessary to contact you for test results or to remind you of your appointment.

We may use or disclose your protected health information in the following situation without your authorization. These situations include: as required by law, public health issues, communicable disease, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement; coroners, funeral directors, and organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, required uses and disclosures, under lay, we must make a disclosure to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirement of section 164.500.

Other permitted and required uses and disclosures will be made only with your consent, authorization, or opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice unless required by law. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in relation to the use or disclosure indicated in the authorization.

Your Rights:

The following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, you may not inspect or copy the following records – psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care and for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restrictions and whom they apply.

Your physician is not required to agree to a restriction that you may request. If the physician believes your restriction is unreasonable and it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If you wish, you then have the right to use another healthcare professional.

You have the right to request and receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e., electronically or by fax.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

Consent to email, cellular telephone, or text usage for appointment reminders and other healthcare communications: I consent to receiving text messages, phone calls or emails reminding me of my appointments.

Note: You may opt out of these communications at any time. The clinic does not charge for this service, but standard text messaging rates or cellular telephone minutes may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

Note: This clinic uses an Electronic Health Record that will update your demographics and consents to the information that you just provided.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints – You may complain to the U.S. Department of Health and Human Services, 200 Independence Ave. S.W. Room 509F, HHH Building, Washington D.C. 20201. If you believe your privacy practices have been violated by us; OR you may file a complaint with us by notifying our HIPAA Privacy Officer. **We will not retaliate against you for filing a complaint.**

This notice was revised, published, and becomes effective on January 16, 2023. We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our privacy officer.

ACKNOWLEDGEMENT

Signature below is only acknowledgement that you have received this Notice of Privacy Practices.

Patient Name: _____ Today's Date: _____

Patient or Guardian Signature: _____ Pt. Date of Birth: _____



Consent to Treatment, Release and Acknowledgement:

Patient Name: _____ Date of Birth: _____

Consent to Treatment:

I request those physicians and other healthcare professionals who care for me to perform routine exams, diagnostic procedures, hospital care and therapeutic treatments which in their judgement become necessary while I am a patient of Cohesive Family Medicine. Routine diagnostic procedures and medical treatments include but are not limited to ECGs, x-rays, physical therapy, blood tests and administration of medications. I also consent to medical recording, or filming when necessary, in the judgement of my physician to document the course of my injury or illness and to provide appropriate medical care, performance improvement and education. I acknowledge that I have the right to request stopping of any recordings during and up until a reasonable time before the recording or film is used. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as to the result of treatment or examinations. I authorize the practice to retain, preserve, and for scientific or educational purposes, dispose of any specimen or tissue taken from my body at their convenience. If I undergo any procedure that requires the submission of tissue for pathologic examination, I authorize the use of any excess tissue for educational purposes. In order to deliver quality healthcare, I understand that Cohesive Family Medicine, including its providers, develop and maintain health information which may include physician notes (both history and physical), medication reports, tests, tests results, and treatment plans. I concur that this health information is used for the following: care and treatment plans, billing statements, communication between interdisciplinary healthcare providers, and verification of services (by both third-party payers and government payers), for quality control by the physician practice.

Reason of Responsibility:

I understand that if I leave the practice without the consent of the physician and/or fail to carry out instructions for follow up care; I do so at my own responsibility. I further understand that any injury or harm I may suffer while away from Cohesive Family Medicine will be my responsibility.

Consent to Appeal:

In the event that my insurance denies payment for any services rendered during this episode of care, I authorize the practice to file a grievance for payment on my behalf. I understand that I have the right to rescind my consent to appeal at any time during the appeal process. If I consent to the practice filing a grievance on my behalf, I understand that I will not be able to file my own grievances concerning these same services, nor will any representative I appoint, unless this consent is rescinded in writing. This consent well be automatically rescinded, and I may file my own grievance if my healthcare provider does not file a grievance, or stops grieving my case.

Statement to Permit Payment of Medicare Benefits to Provider, Physicians and Patients:

I request that payment of authorized Medicare benefits be made on my behalf to the practice for any services furnished to me by that provider of service. I authorize any holder or medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

Statement to Permit Payment of Medicaid Benefits to Provider and Physicians

I certify that the information given by me and in applying for payment under Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information needed for this or related Medicaid claims. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician, the organization furnishing the services, the authorizing physician, or the organization to submit a claim to D.P.W. for payment.

Assignment of Insurance or Payor Benefits

I recognize that I am primarily liable for payments for services rendered; however, in the event that I am entitled to medical care benefits of any type whatsoever, I hereby assign those benefits to Cohesive Family Medicine and any of its contracted healthcare providers. I authorize the practice and the appropriate healthcare providers to apply for benefits of services rendered during this admission for visit. I certify that the insurance or other coverage benefits information supplied by me is correct in accordance with applicable practice, provider, insurance policies or agreements. If my insurance carrier required pre-authorization for services I will receive, I understand that it is my responsibility to contact my personnel office and/or insurance carrier to obtain it. If I fail to do so, I could be liable for all or part of otherwise covered expenses.

Acknowledgement of Responsibility for Payment of Medical Bill

I guarantee payment of all charges incurred for services rendered by Cohesive Family Medicine for the patient's name on the opposite side of this page, less any amounts paid by any third-party payer. I guarantee the amount due for the non-insurable charges including co-payment, deductibles, etc., should my account be referred to an attorney for collections, I agree to pay reasonable attorney's fees and collection expenses.

Acknowledgement of Notice of Privacy Practices

I acknowledge that I have received a copy of the "HIPAA Notice of Privacy Practices". I understand that the information Cohesive Family Medicine acquires or creates about me, will only be disclosed to others for treatment, payment, and healthcare operations as set forth in the notice or as authorized by me in writing.

I certified that I have read this form and that I understand its contents.

Patient Name: _____ Today's Date: _____

Patient or Guardian Signature: _____ Pt. Date of Birth: _____

Cohesive Family Medicine
2508 N. Harrison St.
Shawnee, OK 74804
Phone: 405.585.2030
Fax: 405.857.3122
Cohesivefamilymedicine.com



Authorization to Disclose Health Information:

Yes, I authorize Cohesive Family Medicine to leave me voice messages regarding my protected health information as stated below.

No, I do **NOT** want Cohesive Family Medicine to leave me voice messages.

Patient or Guardian Signature: _____ Date: _____

I hereby authorize Cohesive Family Medicine to release my health information as described in: Medical or Billing

Name: _____ Relationship: _____

Phone: _____

Name: _____ Relationship: _____

Phone: _____

Protected health information may include info/documents regarding medical treatment of the patient including but not limited to diagnosis, procedures, treatment plans, appointments, and test results. As well as account and billing information, including but not limited to, account balances, payment arrangements, insurance claims status and third-party financing.

I understand that the Health Insurance Portability and Accountability Act of 1996, and its implementing regulations govern the terms of the authorization. I understand that I have the right to revoke this authorization at any time prior to the practice's compliance with the request set forth herein, provided that the revocation is in writing.

Signature of Patient or Guardian: _____

Relationship of the Guardian: _____ Date: _____

Cohesive Family Medicine
2508 N. Harrison St.
Shawnee, OK 74804
Phone: 405.585.2030
Fax: 405.857.3122
Cohesivefamilymedicine.com



State Law Regarding Narcotic Prescriptions:

House Bill 2931

Effective January 1, 2020

Patient Name: _____ Birth Date: ____/____/____ Today's Date: ____/____/____

Due to a new State of Oklahoma law, all narcotic medications MUST be sent to pharmacies in electronic form ONLY. Written narcotic scripts are no longer acceptable under this new law.

Please provide your pharmacy information below. **This is the only pharmacy we will use for your medications.**

It is your responsibility to update us on pharmacy changes at least 24 hours before medicines are prescribed. Once your prescription has been sent, it must be picked up at the pharmacy accordingly.

Pharmacy Name: _____

Pharmacy Address: _____

Pharmacy Phone Number: _____

Confirm the above information is correct. As this is where you will be required to pick up your prescriptions.

Patient or Guardian Signature: _____

Cohesive Family Medicine
2508 N. Harrison St.
Shawnee, OK 74804
Phone: 405.585.2030
Fax: 405.857.3122
Cohesivefamilymedicine.com



Authorization for Release of Medical Record Information:

Patient Name: _____ Today's Date: _____

Date of Birth: _____ Patient Phone Number: _____

Address: _____ City/State/Zip: _____

Please Note: Copy Fee May Be Charged for Medical Records

Above listed patient authorizes the following healthcare facility to make record disclosure:

Facility Name: _____ Facility Phone Number: _____

Facility Address: _____ City/State/Zip: _____

Facility Fax Number: _____

Dates and Type of Information to disclose:

- 2 years prior from last date seen
- Dates Other: _____
- Specific Information Requested: _____

The purpose of disclosure is:

- Change of Insurance or Physician
- Continuation of Care
- Referral
- Other _____

RESTRICTIONS: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the dates on this authorization unless other dates specified.

I understand the information in my health record may include information relating to sexually transmitted diseases acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

This information may be disclosed and used by the following individual or organization:

Release To: Cohesive Family Medicine

Address: 2508 N. Harrison City/State/Zip: Shawnee, OK 74804
Fax: 405-857-3122 Phone: 405-585-2030

Please mail records
 Please fax records

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will apply to information that has already been released in response to this authorization. I understand that the revocation will apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____.

If I fail to specify an expiration date, event or condition, this authorization will expire 1 year from the date signed.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information being used or disclosed as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal confidentiality rules. If I have questions about the disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

Signature of Patient/Guardian: _____ Date: _____



Consent to Treat Minor Children:

I, _____, parent or legal guardian of _____, born _____, do hereby consent to any medical care and the administration of anesthesia determined by a physician to be necessary for the welfare of my child while said child is under the care and supervision of _____ and I am not reasonably available by telephone to give consent. (Person given permission to bring minor to the clinic)

This authorization is effective from _____ to _____.
(Today's Date) (Date of your choice)

Signature of Parent or Legal Guardian

Witness Signature

Witness Name (please print)

This consent form should be taken with the child to the hospital or physician's office when the child is taken for treatment.

This additional information will assist in treatment if it can be furnished with the consent but is not required.

Family Address: _____

Telephone: _____ Father's Name: _____ Father's Phone Number: _____

Mother's Name: _____ Mother's Phone Number: _____

Minor's Birthdate: _____ Last Tetanus: _____

Allergies to drugs or foods: _____

Special Medications, Blood Type, or Pertinent Information:

Preferred Hospital: _____



Medical Home Agreement:

This Medical Home Agreement Concept is an AGREEMENT between YOU and YOUR PROVIDER, to focus on meeting ALL your Healthcare Needs.

As your Medical Home Primary Care Provider (PCP), we agree to:

1. Honor your rights as a patient and treat you with dignity and respect.
2. We will focus on listening to your concerns, educating you on your healthcare needs and preventive services.
3. Focus on treating you as a whole person: physically, mentally and emotionally.
4. Focus on providing you with ongoing, quality and safe medical care, including prevention of future health complications.
5. Work to schedule timely office appointments for your chronic and urgent healthcare needs.
6. Be available to you 24 hours a day, by office appointment, phone calls and/or other electronic communication.
7. Provide you with other healthcare resources when we are absent or unavailable.
8. Provide you with referrals to specialists as deemed medically necessary by your PCP.
9. Provide you with treatment, medications, equipment and any other resources deemed medically necessary by your PCP.

As a Medical Patient, your responsibility is the following:

1. Work with us, as your PCP, to meet all your healthcare needs.
2. Communicate with us about all your healthcare concerns and goals.
3. Report any changes related to your health, treatments, medications, etc.
 - a. This includes use of all medications-prescription, over the counter, herbal and street drugs.
 - b. This also includes any medical equipment being used or that has been ordered or recommended for use.
4. Call us before going to the Emergency Room, unless it is life threatening.
5. Notify us after any Emergency Room, Urgent Care Clinic or Hospital visit.
6. Schedule medical appointments in a timely manner, including follow-up appointments.
7. Keep appointments as scheduled with us and any appointments scheduled with a specialist.
8. If you cannot keep an appointment call before your appointment time to cancel or reschedule the appointment.
9. You may be dismissed from your PCP if you repeatedly miss appointments without notice or do not follow the responsibilities listed in the medical home agreement.

Your healthcare is a TEAM approach involving BOTH YOU and YOUR PROVIDER.

Patient Name: _____ Today's Date: _____

Patient Signature: _____ Date of Birth: _____

Witness Name: _____ Today's Date: _____

Witness Signature: _____ Date of Birth: _____